



# COUNTY OF SAN DIEGO

## Department of Environmental Health

### Community Health Division

### Radiological Health Program

5500 Overland Ave Ste 110, San Diego, CA 92123

Tel (858)694-3621 Fax (858)694-3629

PLAN CHECK #: \_\_\_\_\_

ACTIVITY #: \_\_\_\_\_

FEE AMOUNT \$: \_\_\_\_\_

PAYMENT TYPE:

☐ CASH ☐ CHECK \_\_\_\_\_  
Check Number

## RADIATION SHIELDING PLAN CHECK APPLICATION

Plans submitted by: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Facility Name/ Owner's Name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Job Site Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address, if different: \_\_\_\_\_ Zip: \_\_\_\_\_

### X-RAY MACHINE INFORMATION

# of Rooms

Manufacturer

Model/Type

_____	_____	_____
_____	_____	_____

**OWNER/REPRESENTATIVE DECLARATION:** I understand that the fee paid is based on my declaration of the radiation shielding classification. If the declaration is incorrect, I understand that this application will not be approved until the appropriate fee is paid.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**This space for Office Use Only:**

CLASSIFICATION		NO. OF ROOMS	FEES FY '19-20(\$)	TOTAL
DENTAL, MEDICAL, or INDUSTRIAL	FIRST TWO ROOMS (6CRAD----O)		114.00	
	EACH ADDT'L ROOM UP TO 6 (6CRAD----O)		52.00 EACH	
	MORE THAN 6 ROOMS (6CRADHR--O)		IN ADDITION TO \$326 BASE FEE, HOURLY FEE BASED ON REVIEW TIME	